General

Guideline Title

Self-harm: longer-term management.

Bibliographic Source(s)

National Institute for Health and Clinical Excellence (NICE). Self-harm: longer-term management. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Nov. 41 p. (Clinical guideline; no. 133).

Guideline Status

This is the current release of the guideline.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- March 22, 2016 – Opioid pain medicines : The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health (NCCMH) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the Availability of Companion Documents field for the full version of this guidance.

This guideline follows on from Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (NICE clinical guideline 16), which covered the treatment of self-harm within the first 48 hours of an incident.

General Principles of Care

Working with People Who Self-Harm

Health and social care professionals working with people who self-harm should:

- Aim to develop a trusting, supportive and engaging relationship with them
- Be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach
- Ensure that people are fully involved in decision-making about their treatment and care
- Aim to foster people's autonomy and independence wherever possible
- Maintain continuity of therapeutic relationships wherever possible
- Ensure that information about episodes of self-harm is communicated sensitively to other team members

Health and social care professionals who work with people who self-harm should be:

- Familiar with local and national resources, as well as organisations and websites that offer information and/or support for people who self-harm
- Able to discuss and provide advice about access to these resources

Access to Services

Children and young people who self-harm should have access to the full range of treatments and services recommended in this guideline within child and adolescent mental health services (CAMHS).

Ensure that children, young people and adults from black and minority ethnic groups who self-harm have the same access to services as other people who self-harm based on clinical need and that services are culturally appropriate.

When language is a barrier to accessing or engaging with services for people who self-harm, provide them with:

- Information in their preferred language and in an accessible format
- Psychological or other interventions, where needed, in their preferred language
- Independent interpreters

Self-Harm and Learning Disabilities

People with a mild learning disability who self-harm should have access to the same age-appropriate services as other people covered by this guideline.

When self-harm in people with a mild learning disability is managed jointly by mental health and learning disability services, use the Care Programme Approach (CPA).

People with a moderate or severe learning disability and a history of self-harm should be referred as a priority for assessment and treatment conducted by a specialist in learning disabilities services.

Training and Supervision for Health and Social Care Professionals

Health and social care professionals who work with people who self-harm (including children and young people) should be:

- Trained in the assessment, treatment and management of self-harm
- Educated about the stigma and discrimination usually associated with self-harm and the need to avoid judgemental attitudes.

Health and social care professionals who prove training about self-harm should:

- Involve people who self-harm in the planning and delivery of training
- Ensure that training specifically aims to improve the quality and experience of care for people who self-harm
- Assess the effectiveness of training using service-user feedback as an outcome measure

Routine access to senior colleagues for supervision, consultation and support should be provided for health and social care professionals who work with people who self-harm. Consideration should be given of the emotional impact of self-harm on the professional and their capacity to practice competently and empathically.

Consent and Confidentiality

Health and social care professionals who work with people who self-harm should be trained to:

- Understand and apply the principles of the Mental Capacity Act (2005) and Mental Health Act (1983; amended 1995 and 2007)
- Assess mental capacity
- Make decisions about when treatment and care can be given without consent

Be familiar with the principles of confidentiality with regard to information about a person's treatment and care, and be aware of the circumstances in which disclosure of confidential information may be appropriate and necessary.

Offer full written and verbal information about the treatment options for self-harm, and make all efforts necessary to ensure that the person is able, and has the opportunity, to give meaningful and informed consent.

Take into account that a person's capacity to make informed decisions may change over time, and that sometimes this can happen rapidly in the context of self-harm and suicidal behaviour.

Understand when and how the Mental Health Act (1983; amended 1995 and 2007) can be used to treat the physical consequences of self-harm.

Health and social care professionals who work with people who self-harm should have easy access to legal advice about issues relating to capacity and consent.

Health and social care professionals who have contact with children and young people who self-harm should be trained to:

- Understand the different roles and uses of the Mental Capacity Act (2005), the Mental Health Act (1983; amended 1995 and 2007) and the Children Act (1989; amended 2004) in the context of children and young people who self-harm
- Understand how issues of capacity and consent apply to different age groups
- Assess mental capacity in children and young people of different ages

They should also have access at all times to specialist advice about capacity and consent.

Safeguarding

CAMHS professionals who work with children and young people who self-harm should consider whether the child's or young person's needs should be assessed according to local safeguarding procedures.

If children or young people who self-harm are referred to CAMHS under local safeguarding procedures:

- Use a multi-agency approach, including social care and education, to ensure that different perspectives on the child's life are considered
- Consider using the Common Assessment Framework*; advice on this can be sought from the local named lead for safeguarding children

If serious concerns are identified, develop a child protection plan.

When working with people who self-harm, consider the risk of domestic or other violence or exploitation and consider local safeguarding procedures for vulnerable adults and children in their care. Advice on this can be obtained from the local named lead on safeguarding adults.

*It should be noted that the Common Assessment Framework is not applicable in Wales.

Families, Carers and Significant Others*

Ask the person who self-harms whether they would like their family, carers or significant others to be involved in their care. Subject to the person's consent and right to confidentiality, encourage the family, carers or significant others to be involved where appropriate.

When families, carers or significant others are involved in supporting a person who self-harms:

- Offer written and verbal information on self-harm and its management, including how families, carers and significant others can support the person
- Offer contact numbers and information about what to do and whom to contact in a crisis
- Offer information, including contact details, about family and carer support groups and voluntary
- Organisations, and help families, carers or significant others to access these
- Inform them of their right to a formal carer's assessment of their own physical and mental health needs, and how to access this

CAMHS professionals who work with young people who self-harm should balance the developing autonomy and capacity of the young person with perceived risks and the responsibilities and views of parents or carers.

*'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

Managing Endings and Supporting Transitions

Anticipate that the ending of treatment, services or relationships, as well as transitions from one service to another, can provoke strong feelings and increase the risk of self-harm, and:

- Plan in advance these changes with the person who self-harms and provide additional support, if needed, with clear contingency plans should crises occur.
- Record plans for transition to another service and share them with other health and social care professionals involved.
- Give copies to the service user and their family, carers or significant others if this is agreed with the service user.

CAMHS and adult health and social care professionals should work collaboratively to minimise any potential negative effect of transferring young people from CAMHS to adult services.

- Time the transfer to suit the young person, even if it takes place after they reach the age of 18 years.
- Continue treatment in CAMHS beyond 18 years if there is a realistic possibility that this may avoid the need for referral to adult mental health services.

Mental health trusts should work with CAMHS to develop local protocols to govern arrangements for the transition of young people from CAMHS to adult services, as described in this guideline.

Primary Care

If a person presents in primary care with a history of self-harm and a risk of repetition, consider referring them to community mental health services for assessment. If they are under 18 years, consider referring them to CAMHS for assessment. Make referral a priority when:

- Levels of distress are rising, high or sustained
- The risk of self-harm is increasing or unresponsive to attempts to help
- The person requests further help from specialist services
- Levels of distress in parents or carers of children and young people are rising, high or sustained despite attempts to help

If a person who self-harms is receiving treatment or care in primary care as well as secondary care, primary and secondary health and social care professionals should ensure they work cooperatively, routinely sharing up-to-date care and risk management plans. In these circumstances, primary health and social care professionals should attend CPA meetings.

Primary care professionals should monitor the physical health of people who self-harm. Pay attention to the physical consequences of self-harm as well as other physical healthcare needs.

Psychosocial Assessment in Community Mental Health Services and Other Specialist Mental Health Settings: Integrated and Comprehensive Assessment of Needs and Risks

Offer an integrated and comprehensive psychosocial assessment of needs (see recommendations below) and risks (see recommendations below) to understand and engage people who self-harm and to initiate a therapeutic relationship.

Assessment of Needs

Assessment of needs should include:

- Skills, strengths and assets
- Coping strategies
- Mental health problems or disorders
- Physical health problems or disorders
- Social circumstances and problems
- Psychosocial and occupational functioning, and vulnerabilities
- Recent and current life difficulties, including personal and financial problems
- The need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated

conditions
- The needs of any dependent children

All people over 65 years who self-harm should be assessed by mental health professionals experienced in the assessment of older people who self-harm. Assessment should follow the same principles as for working-age adults (see recommendations above). In addition:

- Pay particular attention to the potential presence of depression, cognitive impairment and physical ill health.
- Include a full assessment of the person's social and home situation, including any role they have as a carer.
- Take into account the higher risks of suicide following self-harm in older people.

Follow the same principles as for adults when assessing children and young people who self-harm (see recommendations above), but also include a full assessment of the person's family, social situation, and child protection issues.

During assessment, explore the meaning of self-harm for the person and take into account that:

- Each person who self-harms does so for individual reasons
- Each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode

Risk Assessment

A risk assessment is a detailed clinical assessment that includes the evaluation of a wide range of biological, social and psychological factors that are relevant to the individual and, in the judgement of the healthcare professional conducting the assessment, relevant to future risks, including suicide and self-harm.

When assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:

- Methods and frequency of current and past self-harm
- Current and past suicidal intent
- Depressive symptoms and their relationship to self-harm
- Any psychiatric illness and its relationship to self-harm
- The personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
- Specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
- Coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
- Significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
- Immediate and longer-term risks

Consider the possible presence of other coexisting risk-taking or destructive behaviours, such as engaging in unprotected sexual activity, exposure to unnecessary physical risks, drug misuse or engaging in harmful or hazardous drinking.

When assessing risk, consider asking the person who self-harms about whether they have access to family members', carers' or significant others' medications.

In the initial management of self-harm in children and young people, advise parents and carers of the need to remove all medications or, where possible, other means of self-harm available to the child or young person.

Be aware that all acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise.

Risk Assessment Tools and Scales

Risk assessment tools and scales are usually checklists that can be completed and scored by a clinician or sometimes the service user depending on the nature of the tool or scale. They are designed to give a crude indication of the level of risk (for example, high or low) of a particular outcome, most often suicide.

Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.

Risk assessment tools may be considered to help structure risk assessments as long as they include the areas identified in the recommendations above.

Developing an Integrated Care and Risk Management Plan

Summarise the key areas of needs and risks identified in the assessment (see recommendations above) and use these to develop a care plan (see recommendations below) and a risk management plan (see recommendations below) in conjunction with the person who self-harms and their family, carers or significant others if this is agreed with the person. Provide printed copies for the service user and share them with the general practitioner (GP).

If there is disagreement between health and social care professionals and the person who self-harms about their needs or risks, consider offering the person the opportunity to write this in their notes.

Longer-Term Treatment and Management of Self-Harm

Provision of Care

Mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment (see section on psychosocial assessment above) and the longer-term treatment and management of self-harm. In children and young people this should be the responsibility of tier 2 (primary care) and 3 (community child and adolescent health teams) CAMHS.

Care Plans

Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to:

- Prevent escalation of self-harm
- Reduce harm arising from self-harm or reduce or stop self-harm
- Reduce or stop other risk-related behaviour
- Improve social or occupational functioning
- Improve quality of life
- Improve any associated mental health conditions

Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year.

Care plans should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers or significant others. Care plans should:

- Identify realistic and optimistic long-term goals, including education, employment and occupation
- Identify short-term treatment goals (linked to the long-term goals) and steps to achieve them
- Identify the roles and responsibilities of any team members and the person who self-harms
- Include a jointly prepared risk management plan (see below)
- Be shared with the person's GP

Risk Management Plans

A risk management plan should be a clearly identifiable part of the care plan and should:

- Address each of the long-term and more immediate risks identified in the risk assessment
- Address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide
- Include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail
- Ensure that the risk management plan is consistent with the long-term treatment strategy

Inform the person who self-harms of the limits of confidentiality and that information in the plan may be shared with other professionals.

Update risk management plans regularly for people who continue to be at risk of further self-harm. Monitor changes in risk and specific associated factors for the service user, and evaluate the impact of treatment strategies over time.

Provision of Information about the Treatment and Management of Self-Harm

Offer the person who self-harms relevant written and verbal information about, and give time to discuss with them, the following:

- The dangers and long-term outcomes associated with self-harm
- The available interventions and possible strategies available to help reduce self-harm and/or its consequences (see recommendations under 'General Principles of Care' above and under 'Harm Reduction' below)
- Treatment of any associated mental health conditions (see section below)

Ensure that people who self-harm, and their families, carers and significant others where this is agreed with the person, have access to the 'Understanding NICE guidance' booklet for this guideline and for the short-term management of self-harm (NICE clinical guideline 16).

Interventions for Self-Harm

Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. In addition:

- The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.
- Therapists should be trained and supervised in the therapy they are offering to people who self-harm.
- Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.

Do not offer drug treatment as a specific intervention to reduce self-harm.

Harm Reduction

If stopping self-harm is unrealistic in the short term:

- Consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible.
- Consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team.
- Advise the service user that there is no safe way to self-poison.

Treating Associated Mental Health Conditions

Provide psychological, pharmacological and psychosocial interventions for any associated conditions, for example those described in the following published NICE guidance:

- See the NGC summary of Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline 115)
- See the NICE guideline Depression. The treatment and management of depression in adults (NICE clinical guideline 90)
- See the NGC summary of Psychosis and schizophrenia in adults: treatment and management (NICE clinical guideline 178)
- See the NICE guideline Borderline personality disorder: treatment and management (NICE clinical guideline 78)
- See the NICE guidelines Drug misuse: (psychosocial interventions) or Drug misuse: opioid detoxification (NICE clinical guidelines 51 and 52)
- See the NICE guideline Bipolar disorder (NICE clinical guideline 38)

When prescribing drugs for associated mental health conditions to people who self-harm, take into account the toxicity of the prescribed drugs in overdose. For example, when considering antidepressants, selective serotonin reuptake inhibitors (SSRIs) may be preferred because they are less toxic than other classes of antidepressants. In particular, do not use tricyclic antidepressants, such as dosulepin, because they are more toxic.

Clinical Algorithm(s)

The recommendations from this guideline have been incorporated into a NICE pathway.

Scope

Disease/Condition(s)

Self-harm (including self-poisoning and self-injury)

Note: The term self-harm is used in this guideline to refer to any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This commonly involves self-poisoning with medication or self-injury by cutting. There are several important exclusions that this term is not intended to cover. These include harm to the self arising from excessive consumption of alcohol or recreational drugs, or from starvation arising from anorexia nervosa, or accidental harm to oneself.

Guideline Category

Counseling

Evaluation

Management

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Nursing

Pediatrics

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Emergency Medical Technicians/Paramedics

Health Care Providers

Hospitals

Nurses

Patients

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Guideline Objective(s)

- To make recommendations for the longer-term management of self-harm
- To evaluate the role of specific psychological, psychosocial and pharmacological interventions in the longer-term treatment of self-harm
- To evaluate the role of psychological and psychosocial interventions in combination with pharmacological interventions in the longer-term treatment of self-harm
- To evaluate the role of specific service-level interventions for people who self-harm
- To integrate the above to provide best-practice advice on the longer-term care of individuals (including adults, children and young people) who self-harm
- To promote the implementation of best clinical practice through the development of recommendations tailored to the requirements of the National Health Service (NHS) in England and Wales

Target Population

All people aged 8 years and over who self-harm, and their families/carers

Note: Where the guideline refers to children and young people, this applies to all people who are between 8 and 17 years inclusive. The guideline does not cover people with a neurodevelopmental disorder with repetitive stereotypical self-injurious behaviour (SIB), for example head-banging in people with a significant learning disability.

Interventions and Practices Considered

General Principles of Care

1. Establishing a trusting working relationship with people who self-harm
2. Ensuring access to services for children and young people who self-harm
3. Use of the Care Programme Approach in children with learning disabilities who self-harm
4. Appropriate training and supervision of health and social care professionals who work with people who self-harm
5. Ensuring confidentiality and obtaining appropriate consent for treatment
6. Assessment according to local safeguarding procedures
7. Involvement of families, carers, and significant others in care
8. Managing ending and supporting transitions in treatment

Primary Care

1. Considerations for referral
2. Cooperation among primary and secondary care and social care professionals
3. Monitoring physical health

Psychosocial Assessment in Community Mental Health Services and Other Specialist Mental Health Settings: Integrated and Comprehensive Assessment of Needs and Risks

1. Assessment of needs
2. Risk assessment
3. Developing an integrated care and risk management plan

Longer-Term Treatment and Management of Self-Harm

1. Provision of care by mental health services
2. Establishing aims of care plan
3. Establishing a risk management plan
4. Provision of information about the treatment and management of self-harm
5. Psychological interventions for self-harm
6. Strategies aimed at harm reduction
7. Providing psychological, pharmacological and psychosocial interventions for any associated conditions

Major Outcomes Considered

- Self-harm and self-harm repetition (for example, self-poisoning or self-cutting)
- Suicide
- Quality of life
- Service user determined outcomes
- Secondary outcomes such as social and psychological functioning, other causes of mortality, and resource use

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health (NCCMH) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the Availability of Companion Documents field for the full version of this guidance.

Systematic Clinical Literature Review

Scoping Searches

A broad preliminary search of the literature was undertaken in July 2009 to obtain an overview of the issues likely to be covered by the scope, and to help define key areas. Searches were restricted to clinical guidelines, health technology assessment (HTA) reports, key systematic reviews and randomised controlled trials (RCTs) (see Section 3.5.2 in the full guideline document for a list of websites and databases searched).

Existing NICE guidelines were updated where necessary. Other relevant guidelines were assessed for quality using the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (AGREE Collaboration, 2003). The evidence base underlying high-quality existing guidelines was utilised and updated as appropriate. Further information about this process can be found in The Guidelines Manual (see the Availability of Companion Documents field).

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate all the relevant evidence. Searches were conducted in the following databases:

- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- EMBASE
- MEDLINE/MEDLINE In-Process
- Cochrane Database of Abstracts of Reviews of Effects
- CDSR
- CENTRAL
- HTA database
- Health Management Information Consortium
- International Bibliography of the Social Sciences
- American Psychiatric Association Psychological Information Database (PsycINFO)
- PsycEXTRA
- PsycBOOKS

The search strategies were initially developed for MEDLINE before being translated for use in other databases/interfaces. Strategies were built up

through a number of trial searches, and discussions of the results of the searches with the review team and Guideline Development Group (GDG), to ensure that all possible relevant search terms were covered. To assure comprehensive coverage, search terms for self-harm were kept purposely broad to help counter dissimilarities in database indexing practices, and imprecise reporting of study populations by authors in the titles and abstracts of records.

Refer to the full version of the original guideline document for information about use of Reference Manager, search filters, and date and language restrictions.

Other Search Methods

Other search methods involved were: (1) scanning the reference lists of all eligible publications (systematic reviews, stakeholder evidence and included studies) for more published reports and citations of unpublished research; (2) sending lists of studies meeting the inclusion criteria to subject experts (identified through searches and the GDG) and asking them to check the lists for completeness, and to provide information of any published or unpublished research for consideration (see Appendix 6 of the full version of the original guideline document); (3) checking the tables of contents of key journals for studies that might have been missed by the database and reference list searches; (4) tracking key papers in the Science Citation Index (prospectively) over time for further useful references.

Full details of the search strategies and filters used for the systematic review of clinical evidence are provided in Appendix 9 of the full version of the original guideline document.

Study Selection and Quality Assessment

All primary-level studies included after the first scan of citations were acquired in full and re-evaluated for eligibility at the time they were being entered into the study information database. More specific eligibility criteria were developed for each review question and are described in the relevant clinical evidence chapters. Eligible systematic reviews and primary-level studies were critically appraised for methodological quality (see Appendix 11 of the full version of the original guideline document for methodology checklists). The eligibility of each study was confirmed by at least one member of the GDG.

For some review questions, it was necessary to prioritise the evidence with respect to the UK context (that is, external validity). To make this process explicit, the GDG took into account the following factors when assessing the evidence:

- Participant factors (for example, gender, age and ethnicity)
- Provider factors (for example, model fidelity, the conditions under which the intervention was performed and the availability of experienced staff to undertake the procedure)
- Cultural factors (for example, differences in standard care and differences in the welfare system)

It was the responsibility of the GDG to decide which prioritisation factors were relevant to each review question in light of the UK context and then decide how they should modify their recommendations.

Unpublished Evidence

The GDG used a number of criteria when deciding whether or not to accept unpublished data. First, the evidence must have been accompanied by a trial report containing sufficient detail to properly assess the quality of the data. Second, the evidence must have been submitted with the understanding that data from the study and a summary of the study's characteristics would be published in the full guideline. Therefore, the GDG did not accept evidence submitted as commercial in confidence. However, the GDG recognised that unpublished evidence submitted by investigators might later be retracted by those investigators if the inclusion of such data would jeopardise publication of their research.

Search Strategy for Economic Evidence

Scoping Searches

A broad preliminary search of the literature was undertaken in July 2009 to obtain an overview of the issues likely to be covered by the scope, and help define key areas. Searches were restricted to economic studies and HTA reports, and conducted in the following databases:

- EMBASE
- MEDLINE/MEDLINE In-Process
- HTA database (technology assessments)
- NHS Economic Evaluation Database

Any relevant economic evidence arising from the clinical scoping searches was also made available to the health economist during the same period.

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate all the relevant evidence. Searches were restricted to economic evidence (including full and partial economic evaluations) and HTA reports, and conducted in the following databases:

- CINAHL
- EconLit
- EMBASE
- MEDLINE/MEDLINE In-Process
- PsycINFO
- HTA database (technology assessments)
- NHS Economic Evaluation Database

Any relevant economic evidence arising from the clinical searches was also made available to the health economist during the same period.

The search strategies were initially developed for MEDLINE before being translated for use in other databases/interfaces. Strategies were built up through a number of trial searches, and discussions of the results of the searches with the review team and GDG, to ensure that all possible relevant search terms were covered. To assure comprehensive coverage, search terms for self-harm were kept purposely broad to help counter dissimilarities in database indexing practices, and imprecise reporting of study populations by authors in the titles and abstracts of records.

Refer to the full version of the original guideline document for more information about the use of Reference Manager, search filters, and date and language restrictions.

Other Search Methods

Other search methods involved scanning the reference lists of all eligible publications (systematic reviews, stakeholder evidence and included studies from the economic and clinical reviews) to identify further studies for consideration. Full details of the search strategies and filter used for the systematic review of health economic evidence are provided in Appendix 12 of the full version of the original guideline document.

Inclusion Criteria for Economic Studies

The following inclusion criteria were applied to select studies identified by the economic searches for further consideration:

- Only studies from Organisation for Economic Co-operation and Development countries were included, because the aim of the review was to identify economic information transferable to the UK context.
- Selection criteria based on types of clinical conditions and patients as well as interventions assessed were identical to the clinical literature review.
- Studies were included provided that sufficient details regarding methods and results were available to enable the methodological quality of the study to be assessed, and provided that the study's data and results were extractable. Poster presentations of abstracts were excluded.
- Full economic evaluations that compared two or more relevant options and considered both costs and consequences were included in the review.
- Economic studies were included if they used clinical effectiveness data from an RCT, a prospective cohort study, or a systematic review and meta-analysis of clinical studies. Studies that had a mirror-image or other retrospective design were excluded from the review.
- Studies were included only if the examined interventions were clearly described. This involved the dosage and route of administration and the duration of treatment in the case of pharmacological therapies; and the types of health professionals involved as well as the frequency and duration of treatment in the case of psychological interventions. Evaluations in which medications were treated as a class were excluded from further consideration.
- Studies that adopted a very narrow perspective, ignoring major categories of costs to the NHS, were excluded; for example studies that estimated exclusively drug acquisition costs or hospitalisation costs were considered non-informative to the guideline development process.

Results of the Systematic Search of Economic Literature

The titles of all studies identified by the systematic search of the literature were screened for their relevance to the topic (that is, economic issues and information on health-related quality of life in people who self-harm). References that were clearly not relevant were excluded first. The abstracts of all potentially relevant studies (12 references) were then assessed against the inclusion criteria for economic evaluations by the health economist. Full texts of the studies potentially meeting the inclusion criteria (including those for which eligibility was not clear from the abstract) were obtained. Studies that did not meet the inclusion criteria, were duplicates, were secondary publications of one study, or had been updated in more recent publications were subsequently excluded. Finally, two economic studies that fully or partially met the applicability and quality criteria

were considered at formulation of the guideline recommendations.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Overall Quality of Outcome Evidence in Grading of Recommendations, Assessment, Development and Evaluation (GRADE)

Quality Element	Description
High	Further research is very unlikely to change confidence in the estimate of effect.
Moderate	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.
Low	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.
Very low	Any estimate of effect is very uncertain.

Methods Used to Analyze the Evidence

Meta-Analysis

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health (NCCMH) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the Availability of Companion Documents field for the full version of this guidance.

Data Extraction

Study characteristics and outcome data were extracted from all eligible studies that met the minimum quality criteria, using a bespoke database and Review Manager 5.0.25 and/or Word-based forms (see Appendix 11 of the full version of the original guideline document).

In most circumstances, for a given outcome (continuous and dichotomous), where more than 50% of the number randomised to any group were lost to follow-up, the data were excluded from the analysis (except for the outcome 'leaving the study early', in which case the denominator was the number randomised). Where possible, dichotomous efficacy outcomes were calculated on an intention-to-treat basis (that is, a 'once-randomised-always-analyse' basis). Where there was good evidence that those participants who ceased to engage in the study were likely to have an unfavourable outcome, early withdrawals were included in both the numerator and denominator. Adverse effects were entered into Review Manager as reported by the study authors because it is usually not possible to determine whether early withdrawals had an unfavourable outcome. Where there was limited data for a particular review, the 50% rule was not applied. In these circumstances the evidence was downgraded due to the risk of bias.

Where some of the studies failed to report standard deviations (SDs) (for a continuous outcome) and where an estimate of the variance could not be computed from other reported data or obtained from the study author, the following approach was taken.

When the number of studies with missing SDs was less than one third and when the total number of studies was at least ten, the pooled SD was imputed (calculated from all the other studies in the same meta-analysis that used the same version of the outcome measure). In this case, the appropriateness of the imputation was made by comparing the standardised mean differences (SMDs) of those trials that had reported SDs against the hypothetical SMDs of the same trials based on the imputed SDs. If they converged, the meta-analytical results were considered to be reliable.

When the conditions above could not be met, SDs were taken from another related systematic review (if available). In this case, the results were considered to be less reliable.

The meta-analysis of survival data was based on log hazard ratios and standard errors. Because individual patient data were not available in included studies, hazard ratios and standard errors calculated from a Cox proportional hazard model were extracted. Where necessary, standard errors were calculated from confidence intervals (CIs) or p-value according to standard formulae. Data were summarised using the generic inverse variance method using Review Manager.

Consultation with another reviewer or members of the Guideline Development Group (GDG) was used to overcome difficulties with coding. Data from studies included in existing systematic reviews were extracted independently by one reviewer and cross-checked with the existing data set. Where possible, two independent reviewers extracted data from new studies. Where double data extraction was not possible, data extracted by one reviewer was checked by the second reviewer. Disagreements were resolved through discussion. Where consensus could not be reached, a third reviewer or GDG members resolved the disagreement. Masked assessment (that is, blind to the journal from which the article comes, the authors, the institution and the magnitude of the effect) was not used because it is unclear that doing so reduces bias.

Synthesising the Evidence

Meta-analysis

Where possible, meta-analysis was used to synthesise the evidence using Review Manager. If necessary, re-analyses of the data or sub-analyses were used to answer review questions not addressed in the original studies or reviews.

Dichotomous outcomes were analysed as relative risks (RR) with the associated 95% CI. The CI shows a range of values within which we are 95% confident that the true effect will lie. If the effect size has a CI that does not cross the 'line of no effect', then the effect is commonly interpreted as being statistically significant.

Continuous outcomes were analysed using the mean difference, or SMD when different measures were used in different studies to estimate the same underlying effect. If reported by study authors, intention-to-treat data, using a valid method for imputation of missing data, were preferred over data only from people who completed the study.

Heterogeneity

To check for consistency of effects among studies, both the I^2 statistic and the chi-squared test of heterogeneity, as well as a visual inspection of the forest plots were used.

Publication Bias

Where there was sufficient data, reviewers intended to use funnel plots to explore the possibility of publication bias. Asymmetry of the plot would be taken to indicate possible publication bias and investigated further. Where necessary, an estimate of the proportion of eligible data that were missing (because some studies did not include all relevant outcomes) was calculated for each analysis.

Presenting the Data to the Guideline Development Group

Study characteristics tables and, where appropriate, forest plots generated with Review Manager were presented to the GDG.

Where meta-analysis was not appropriate and/or possible, the reported results from each primary-level study were included in the study characteristics table (and where appropriate, in a narrative review).

Evidence Profile Tables

A GRADE (Grading of Recommendations Assessments, Development and Evaluation) evidence profile was used to summarise both the quality of the evidence and the results of the evidence synthesis (see Table 3 in the full version of the original guideline for an example of an evidence profile). The GRADE approach is based on a sequential assessment of the quality of evidence, followed by judgment about the balance between desirable and undesirable effects, and subsequent decision about the strength of a recommendation.

For each outcome, quality may be reduced depending on the following factors:

- Study design (randomised trial, observational study, or any other evidence)
- Limitations (based on the quality of individual studies)
- Inconsistency (see Section 3.5.4 in the full version of the original guideline document for how consistency was assessed)
- Indirectness (that is, how closely the outcome measures, interventions and participants match those of interest)
- Imprecision (based on the CI around the effect size)

For observational studies, the quality may be increased if there is a large effect, plausible confounding would have changed the effect, or there is evidence of a dose–response gradient (details would be provided under the other considerations column). Each evidence profile also included a summary of the findings: number of patients included in each group, an estimate of the magnitude of the effect and the overall quality of the evidence for each outcome.

Health Economics Methods

The aim of the health economics was to contribute to the guideline's development by providing evidence on the cost effectiveness of interventions for the longer-term management of self-harm covered in the guideline. This was achieved by:

- Systematic literature review of existing economic evidence
- Decision-analytic economic modelling

Systematic reviews of economic literature were conducted in all areas covered in the guideline. Economic modelling was undertaken in areas with likely major resource implications, where the current extent of uncertainty over cost effectiveness was significant and economic analysis was expected to reduce this uncertainty, in accordance with The Guidelines Manual. Prioritisation of areas for economic modelling was a joint decision between the Health Economist and the GDG. The rationale for prioritising review questions for economic modelling was set out in an economic plan agreed between NICE, the GDG, the health economist and the other members of the technical team. The economic question selected as a key issue addressed by economic modelling was:

- Cost-effectiveness of psychological intervention and treatment as usual for prevention of self-harm repetition among people who self-harm.

In addition, literature on the health-related quality of life (HRQoL) of people who self-harm was systematically searched to identify studies reporting appropriate utility scores that could be utilised in a cost-utility analysis. Methods employed in economic modelling are described in the respective sections of the full version of the original guideline.

Applicability and Quality Criteria for Economic Studies

All economic papers eligible for inclusion were appraised for their applicability and quality using the methodology checklist for economic evaluations recommended by NICE, which is shown in Appendix 13 of the full version of the original guideline document. The methodology checklist for economic evaluations was also applied to the economic models developed specifically for the guideline. All studies that fully or partially met the applicability and quality criteria described in the methodology checklist were considered during the guideline development process, along with the results of the economic modelling conducted specifically for the guideline.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health (NCCMH) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the Availability of Companion Documents field for the full version of this guidance.

The Guideline Development Group

The Guideline Development Group (GDG) consisted of: professionals in psychiatry, clinical psychology, nursing, social work and general practice; academic experts in psychiatry and psychology; a service user; and representatives from service user organisations. The carer perspective was provided through topic group discussion with carers. The service user topic group meetings were coordinated between the staff from NCCMH,

the service user and carer representative. The guideline development process was supported by staff from the NCCMH, who undertook the clinical and health economics literature searches, reviewed and presented the evidence to the GDG, managed the process, and contributed to drafting the guideline.

Guideline Development Group Meetings

Thirteen GDG meetings were held between November 2009 and June 2010. During each day-long GDG meeting, in a plenary session, review questions and clinical and economic evidence were reviewed and assessed, and recommendations formulated. At each meeting, all GDG members declared any potential conflicts of interest, and service user and carer concerns were routinely discussed as part of a standing agenda.

Service Users and Carers

Individuals with direct experience of services gave an integral service-user focus to the GDG and the guideline. The GDG included a service user and representatives of a national service user group. They contributed as full GDG members to writing the review questions, helping to ensure that the evidence addressed their views and preferences, highlighting sensitive issues and terminology relevant to the guideline, and bringing service-user research to the attention of the GDG. In drafting the guideline, they contributed to writing the guideline's introduction, Chapter 4 and identified recommendations from the service user and carer perspective.

Special Advisors

Special advisors, who had specific expertise in one or more aspects of treatment and management relevant to the guideline, assisted the GDG, commenting on specific aspects of the developing guideline and making presentations to the GDG. Appendix 3 in the full version of the original guideline lists those who agreed to act as special advisors.

National and International Experts

National and international experts in the area under review were identified through the literature search and through the experience of the GDG members. These experts were contacted to recommend unpublished or soon-to-be published studies, to ensure that up-to-date evidence was included in the development of the guideline. They informed the group about completed trials at the pre-publication stage, systematic reviews in the process of being published, studies relating to the cost effectiveness of treatment and trial data if the GDG could be provided with full access to the complete trial report. Appendix 6 in the full version of the original guideline lists researchers who were contacted.

Forming the Clinical Summaries and Recommendations

Once the Grading of Recommendations Assessment, Development and Evaluation (GRADE) evidence profiles relating to a particular review question were completed, summary evidence tables were developed (these tables are presented in the evidence chapters). Finally, the systematic reviewer in conjunction with the Guideline Development Group (GDG) produced a clinical evidence summary.

After the GRADE profiles and clinical summaries were presented to the GDG, the associated recommendations were drafted. In making recommendations, the GDG took into account the trade-off between the benefits and downsides of treatment as well as other important factors, such as economic considerations, social value judgements, the requirements to prevent discrimination and to promote equality, and the group's awareness of practical issues.

Finally, to show clearly how the GDG moved from the evidence to the recommendations, each chapter has a section called 'from evidence to recommendations'. Underpinning this section is the concept of the 'strength' of a recommendation. This takes into account the quality of the evidence but is conceptually different. Some recommendations are 'strong' in that the GDG believes that the vast majority of healthcare professionals and service users would choose a particular intervention if they considered the evidence in the same way that the GDG has. This is generally the case if the benefits clearly outweigh the harms for most people and the intervention is likely to be cost effective. However, there is often a closer balance between benefits and harms, and some service users would not choose an intervention whereas others would. This may happen, for example, if some service users are particularly averse to some side effect and others are not. In these circumstances the recommendation is generally weaker, although it may be possible to make stronger recommendations about specific groups of service users. The strength of each recommendation is reflected in the wording of the recommendation, rather than by using labels or symbols.

Where the GDG identified areas in which there are uncertainties or where robust evidence was lacking, they developed research recommendations. Those that were identified as 'high-priority' were included in the NICE version of the guideline.

Method Used to Answer a Review Question in the Absence of Appropriately Designed, High-Quality Research

In the absence of appropriately designed, high-quality research, or where the GDG were of the opinion (on the basis of previous searches or their knowledge of the literature) that there were unlikely to be such evidence, an informal consensus process was adopted. This process focused on

those questions that the GDG considered a priority.

Informal Consensus

The starting point for the process of informal consensus was that a member of the GDG identified, with help from the systematic reviewer, a narrative review or key study that most directly addressed the review question. Where this was not possible, a brief review of the recent literature was initiated. These were then used as a basis for beginning an iterative process to identify lower levels of evidence relevant to the review question and to lead to written statements for the guideline. The process involved a number of steps:

1. A description of what is known about the issues concerning the clinical question was written by one of the GDG members.
2. Evidence from the existing studies was then presented in narrative form to the GDG and further comments were sought about the evidence and its perceived relevance to the review question.
3. Based on the feedback from the GDG, additional information was sought and added to the information collected. This included studies that did not directly address the review question but were thought to contain relevant data.
4. A summary of statements that directly addressed the review question were then developed.
5. Following this, on occasions and as deemed appropriate by the development group, the report was then sent to appointed experts outside of the GDG for peer review and comment. The information from this process was then fed back to the GDG for further discussion of the statements
6. Recommendations were then developed and could also be sent for further external peer review.
7. After this final stage of comment, the statements and recommendations were again reviewed and agreed upon by the GDG.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

The economic evidence considered in the full version of the guideline (see the Availability of Companion Documents field) is provided in the respective evidence chapters, following presentation of the relevant clinical evidence. The references to included studies and the respective evidence tables with the study characteristics and results are provided in Appendix 14 of the full version of the original guideline. Methods and results of economic modelling undertaken alongside the guideline development process are presented in the relevant evidence chapters. Characteristics and results of all economic studies considered during the guideline development process (including modelling studies conducted for this guideline) are summarised in economic evidence profiles accompanying respective GRADE (Grading of Recommendations Assessments, Development and Evaluation) clinical evidence profiles in Appendix 17 of the full version of the guideline.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Registered stakeholders had an opportunity to comment on the draft guideline, which was posted on the National Institute for Health and Clinical Excellence (NICE) website during the consultation period. Following the consultation, all comments from stakeholders and others were responded to, and the guideline updated as appropriate. The Guideline Review Panel also reviewed the guideline and checked that stakeholders' comments had been addressed. Following the consultation period, the Guideline Development Group finalised the recommendations and the National Collaborating Centre for Mental Health (NCCMH) produced the final documents. These were then submitted to NICE for the pre-publication check where stakeholders are given the opportunity to highlight factual errors. Any errors are corrected by the NCCMH, then the guideline is formally approved by NICE and issued as guidance to the NHS in England and Wales.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is not specifically stated.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Implementation of the recommendations may ensure that people who self-harm receive appropriate long-term management and care to improve outcomes and minimise the recurrence of self harm, suicide ideation and depression.
- From the health economic evidence, there is some evidence to suggest that psychosocial intervention is potentially cost-effective in reducing repetition of self-harm episodes. In the long term, its health and economic benefit is also significant.

Potential Harms

- Stigma and misconceptions regarding self-harm from others
- Certain classes of antidepressants (for example, selective serotonin reuptake inhibitors [SSRIs]) may be associated with an increase in suicidal behaviour particularly in young people.
- Those who self-harm are at increased risk of future episodes, including overdoses of medication. There are large differences in the toxicity of medication prescribed to people who self-harm.

Qualifying Statements

Qualifying Statements

- This guidance represents the view of the National Institute for Health and Clinical Excellence (NICE), which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.
- Treatment and care should take into account service users' needs and preferences. People who self-harm should have the opportunity to make informed decisions about their care and treatment, in partnership with health and social care professionals. If service users do not have the capacity to make decisions, health and social care professionals should follow the guidance in the code of practice that accompanies the Mental Capacity Act. In Wales, healthcare professionals should follow advice on consent from the Welsh Government. If the service user is under 16, health and social care professionals should follow the guidelines in 'Seeking consent: working with children'.

Implementation of the Guideline

Description of Implementation Strategy

The National Institute for Health and Clinical Excellence (NICE) has developed tools to help organisations implement this guidance (http://guidance.nice.org.uk/CG133).

Key Priorities for Implementation

The following recommendations have been identified as priorities for implementation.

Working with People Who Self-Harm

Health and social care professionals working with people who self-harm should:

- Aim to develop a trusting, supportive and engaging relationship with them
- Be aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach
- Ensure that people are fully involved in decision-making about their treatment and care
- Aim to foster people's autonomy and independence wherever possible
- Maintain continuity of therapeutic relationships wherever possible
- Ensure that information about episodes of self-harm is communicated sensitively to other team members

Psychosocial Assessment

Offer an integrated and comprehensive psychosocial assessment of needs and risks to understand and engage people who self-harm and to initiate a therapeutic relationship.

Assessment of needs should include:

- Skills, strengths and assets
- Coping strategies
- Mental health problems or disorders
- Physical health problems or disorders
- Social circumstances and problems
- Psychosocial and occupational functioning, and vulnerabilities
- Recent and current life difficulties, including personal and financial problems
- The need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions
- The needs of any dependent children

Risk Assessment

When assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them, taking into account:

- Methods and frequency of current and past self-harm
- Current and past suicidal intent
- Depressive symptoms and their relationship to self-harm
- Any psychiatric illness and its relationship to self-harm
- The personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
- Specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
- Coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
- Significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
- Immediate and longer-term risks

Risk Assessment Tools and Scales

Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

Care Plans

Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to:

- Prevent escalation of self-harm
- Reduce harm arising from self-harm or reduce or stop self-harm
- Reduce or stop other risk-related behaviour
- Improve social or occupational functioning
- Improve quality of life
- Improve any associated mental health conditions

Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year.

Care plans should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers or significant others.*

Care plans should:

- Identify realistic and optimistic long-term goals, including education, employment and occupation
- Identify short-term treatment goals (linked to the long-term goals) and steps to achieve them
- Identify the roles and responsibilities of any team members and the person who self-harms
- Include a jointly prepared risk management plan
- Be shared with the person's general practitioner (GP)

*'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them.

Risk Management Plans

A risk management plan should be a clearly identifiable part of the care plan and should:

- Address each of the long-term and more immediate risks identified in the risk assessment
- Address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide
- Include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail
- Ensure that the risk management plan is consistent with the long-term treatment strategy

Inform the person who self-harms of the limits of confidentiality and that information in the plan may be shared with other professionals.

Interventions for Self-Harm

Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. In addition:

- The intervention should be tailored to individual need and could include cognitive, behavioural, psychodynamic or problem-solving elements.
- Therapists should be trained and supervised in the therapy they are offering to people who self-harm.
- Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.

Do not offer drug treatment as a specific intervention to reduce self-harm.

Treating Associated Mental Health Conditions

Provide psychological, pharmacological and psychosocial interventions for any associated conditions, for example those described in the following published NICE guidance:

- See the NGC summary of Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline 115)
- See the NICE guideline Depression. The treatment and management of depression in adults (NICE clinical guideline 90)
- See the NGC summary of Psychosis and schizophrenia in adults: treatment and management (NICE clinical guideline 178)
- See the NICE guideline Borderline personality disorder: treatment and management (NICE clinical guideline 78)
- See the NICE guideline Drug misuse: (psychosocial interventions) or Drug misuse: opioid detoxification (NICE clinical guidelines 51 and 52)
- Bipolar disorder (NICE clinical guideline 38)

Implementation Tools

Audit Criteria/Indicators

Clinical Algorithm

Foreign Language Translations

Patient Resources

Quick Reference Guides/Physician Guides

Resources

Slide Presentation

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

National Institute for Health and Clinical Excellence (NICE). Self-harm: longer-term management. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Nov. 41 p. (Clinical guideline; no. 133).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2011 Nov

Guideline Developer(s)

National Collaborating Centre for Mental Health - National Government Agency [Non-U.S.]

Source(s) of Funding

National Institute for Health and Clinical Excellence (NICE)

Guideline Committee

Guideline Development Group (GDG)

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Financial Disclosures/Conflicts of Interest

To minimise and manage any potential conflicts of interest, and to avoid any public concern that commercial or other financial interests have affected the work of the GDG and influenced guidance, members of the GDG must declare as a matter of public record any interests held by themselves or their families which fall under specified categories. These categories include any relationships they have with the healthcare industries, professional organisations and organisations for people with psychosis and substance misuse and their families/carers.

Individuals invited to join the GDG were asked to declare their interests before being appointed. To allow the management of any potential conflicts of interest that might arise during the development of the guideline, GDG members were also asked to declare their interests at each GDG meeting throughout the guideline development process. The interests of all the members of the GDG are listed in Appendix 2 of the full version of the guideline, including interests declared prior to appointment and during the guideline development process.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the National Institute for Clinical Excellence (NICE) Web site.

Availability of Companion Documents

The following are available:

- Self harm. The NICE guideline on longer-term management. Full guideline. London (UK): National Institute for Clinical Excellence (NICE); 2011 Nov. 416 p. (Clinical guideline; no. 133). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Self harm. The NICE guideline on longer-term management. Appendices. London (UK): National Institute for Clinical Excellence (NICE); 2011 Nov. Various p. (Clinical guideline; no. 133). Electronic copies: Available in PDF from the NICE Web site.
- NICE Pathways. Self-harm. Electronic copies: Available from the NICE Web site.
- Self-harm: longer term management. Clinical audit tools. National Institute for Health and Clinical Excellence (NICE); 2011 Nov. Various p. (Clinical guideline; no. 133). Electronic copies: Available from the NICE Web site.
- Self-harm: longer-term management. Electronic audit tools. National Institute for Health and Clinical Excellence (NICE); 2011. (Clinical guideline; no. 133). Electronic copies: Available from the NICE Web site.
- Self-harm: longer-term management. Costing report. National Institute for Health and Clinical Excellence (NICE); 2011 Nov. 35 p. (Clinical guideline; no. 133). Electronic copies: Available in PDF from the NICE Web site.
- Self-harm: longer-term management. Costing template. National Institute for Health and Clinical Excellence (NICE); 2011. (Clinical guideline; no. 133). Electronic copies: Available from the NICE Web site.
- Self-harm: longer-term management. Slide set. National Institute for Health and Clinical Excellence (NICE); 2011 Nov. 35 p. (Clinical guideline; no. 133). Electronic copies: Available from the NICE Web site.
- Self-harm: longer-term management. Baseline assessment tool. National Institute for Health and Clinical Excellence (NICE); 2011. (Clinical guideline; no. 133). Electronic copies: Available from the NICE Web site.
- Self-harm: longer-term management. Clinical case scenarios for health and social care professionals. National Institute for Health and Clinical Excellence (NICE); 2012 Feb. 68 p. (Clinical guideline; no. 133). Electronic copies: Available in PDF from the NICE Web site.
- Self-harm. Support for education and learning: Clinical case scenarios for health and social care professionals. Slide set. National Institute for Health and Clinical Excellence (NICE); 2012 Mar. 82 p. (Clinical guideline; no. 133). Electronic copies: Available from the NICE Web site.
- Self-harm: risk assessment podcast. National Institute for Health and Clinical Excellence (NICE); 2011 Nov. Electronic copies: Available from the NICE Web site.
- Self-harm: service user podcast. National Institute for Health and Clinical Excellence (NICE); 2011 Nov. Electronic copies: Available from the NICE Web site.
- The guidelines manual 2009. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jan. Electronic copies: Available in PDF from the NICE Archive Web site.

Patient Resources

The following is available:

- Longer-term care and treatment of self-harm. Understanding NICE guidance. Information for people who use NHS services. London: National Institute for Health and Clinical Excellence (NICE); 2011 Nov. 16 p. Electronic copies: Available from the National Institute for Health and Clinical Excellence (NICE) Web site. Also available in Welsh from the NICE Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on June 26, 2012. This summary was updated by ECRI Institute on June 2, 2016 following the U.S. Food and Drug Administration advisory on Opioid pain medicines.

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